

**SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO PARTICIPANTS**

**NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND**

(Plan No.: 501; I.D. No.: 15-0551885)

July 30, 2009

Dear Participant:

This letter contains important information regarding changes adopted by the Board of Trustees of the New York State Teamsters Council Health and Hospital Fund (the "Fund"). As explained below, some of the changes will be effective October 1, 2009 and others will be effective January 1, 2010. Please read this letter carefully and keep it with your copy of the Summary Plan Description for the Fund.

Effective October 1, 2009, the following changes will occur:

CHANGES IN THE SUPREME (INDEMNITY) PLAN

- **A \$10 co-pay will be required for the following physician services (previously required no co-pay).**

- | | |
|--|--|
| - Diagnostic Office visits | - Office / Outpatient Consultations |
| - Mental Health Care visits | - Chemical Dependency visits |
| - Office Surgery | - Second Surgical / Medical Opinion |
| - In Hospital Physician visits | - Routine Physical Exams |
| - Well Child Visits & Immunizations | - Adult Immunizations |
| - Diagnostic Eye Exams | - Routine Eye Exams (child up to age 19) |
| - Diagnostic GYN visit | - Allergy Testing and Treatment |
| - Allergy Serum | - Chiropractic Care |
| - Inpatient Consultations | - Treatment of Diabetes (non pharmacy) |
| - Urgent Care Center | - Emergency Room Physician visit |
| - Physical / Occupational Therapy | - Speech/Respiratory Therapy |
| - Pulmonary / Cardiac Rehabilitation Therapy | |

- **A \$100 co-pay will be required for Emergency Room visits that do not result in an inpatient hospital admission (previously required no co-pay).**
- **New member ID cards will be issued by Excellus BlueCross BlueShield based upon the approved conversion to a new processing platform. Excellus expects to mail the cards during the middle of September with all delivered by September 26, 2009.**

CHANGES IN THE SELECT (PPO) PLAN

- A \$20 co-pay will be required for the following physician services and diagnostic testing services (previously required a \$15 co-pay).

- Diagnostic Office visits
- Mental Health Care visits
- Office Surgery
- In Hospital Physician visits
- Well Child Visits & Immunizations
- Diagnostic Eye Exams
- Diagnostic GYN visits
- Allergy Serum
- Inpatient Consultations
- Urgent Care Center
- Mammogram and Pap Smear
- Physical / Occupational Therapy
- Home Health Care
- Newborn Care
- Laboratory / Pathology
- Pulmonary / Cardiac Rehabilitation Therapy
- Office / Outpatient Consultations
- Chemical Dependency visits
- Second Surgical / Medical Opinion
- Routine Physical Exams
- Adult Immunizations
- Routine Eye Exams (child up to age 19)
- Allergy Testing & Treatment
- Chiropractic care
- Treatment of Diabetes (non pharmacy)
- Emergency Room Physician visit
- Bone Density Testing
- Kidney Dialysis
- Prostate Cancer Screenings -
- Radiation and Chemo Therapy
- Speech/Respiratory Therapy

- A \$30 co-pay will be required for the following diagnostic services (previously required a \$15 co-pay).

- Outpatient Surgery / Surgicenters
- Diagnostic X-Rays & Imaging
- Pre Admission Testing
- Diagnostic Machine Tests

- A \$100 co-pay will be required for Emergency Room visits that do not result in an inpatient hospital admission (previously required a \$50 co-pay).

Effective January 1, 2010, the following changes will occur:

CHANGES IN THE SELECT (PPO) PLAN

Coinsurance: Covered in-network services currently reimbursed by the Fund at 100% of the allowable amount will be reimbursed at 95%, up to an annual out of pocket maximum of \$1,000 per individual and \$3,000 per family. Once the annual out of pocket maximum is reached, all covered services will be reimbursed at 100% of the allowable amount.

- The following covered in-network services are impacted :

- Inpatient Hospital Services
- Acute Inpatient Mental Health Care
- Acute Inpatient Chemical Dependency Care
- Skilled Nursing Facility
- Durable Medical Equipment / Medical Supplies / Prosthetics
- Observation Stays
- Detoxification
- Anesthesia
- Maternity Care / Birthing Centers

GENERAL ELIGIBILITY CHANGES THAT AFFECT ALL PLANS

- NO "OPT OUT" PROVISION FOR SPOUSE'S COVERAGE.

Currently, if your spouse is eligible to be covered under his/her employer's benefit plan as an employee and is eligible for such group coverage at no cost or a cost of 2% or less of your spouse's wage, or receives a monetary payment for declining that coverage, and your spouse does not enroll in such coverage (opts out), your spouse may not be covered as an eligible dependent under this Plan.

Effective January 1, 2010, if your spouse is eligible to be covered under a separate group medical plan as an employee and such group coverage is available at **no cost or a cost of 5% or less of the spouse's wages**, or receives a monetary payment for declining that coverage, the spouse may *not* "opt out" of that coverage.

The Fund Office will supply the form that needs to be completed by your spouse's employer to verify the cost and coverage available.

All spouses will need to re-qualify for this provision annually beginning in 2010. Re-qualification will begin during the fourth quarter of each year.

If you have any questions, please contact the Fund Office at 315.455.9790 or 1.877.698.3863 and select Option 1.

Sincerely,

BOARD OF TRUSTEES
NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND

New York State Teamsters Council Health and Hospital Fund

PO Box 4928
Syracuse, NY 13221-4928
Telephone: 315.455.9790
Fax: 315.234.1046
E-mail: benefits@nytfund.org

July 30, 2009

Re: Change in Coordination of Benefit "Opt Out" percentage

Dear Participant:

With the escalation of health care costs and the difficult economic times facing the Health & Hospital Fund, the Board of Trustees is raising the "Opt Out" percentage and will be requiring every spouse to re-qualify under this provision of the plan.

The current plan provision states:

"If your husband or wife is eligible to be covered under a separate group medical plan as an employee and such group coverage is available at **no cost or a cost of 2% or less of the spouse's wages**, the spouse may not "opt out" of coverage. The Fund Office provides a form to be completed by your spouse's employer to verify the cost and coverage available."

For coverage beginning **January 1, 2010** this percent is being increased to **5%**. If the cost of a comparable single or family coverage medical plan for your spouse is **5% or less** of the spouse's wage, your spouse must enroll in his or her employer's plan and the dependent's will be covered according to the Fund's Birthday Rule as detailed in the General Eligibility & ERISA Rights Information Section 5 A (3) (c).

This Section reads as follows:

"If a child is covered as a dependent of two people, (parent/married or joint custodians of the child without a court decree establishing financial responsibility for health care expenses), under different programs the following rules apply:

1. The program of the parent whose birthday (month and day) is earlier in the year is primary.
2. If both parents have the same birthday, the program which covered a parent longer is primary; however,
3. If the parents are divorced or separated, and joint custody has not been decreed, the special rule in (d) may apply.

When another program has not adopted the birthday rule, and the two plans do not agree which program is primary, the program under which the child is a dependent of a male is primary.

At a minimum the spouse must enroll for single coverage and the Fund's plan will provide secondary coverage. The Fund will continue to supply the coverage for dependent children, unless it is provided to them without charge under your spouse's plan. The standard Coordination of Benefit rules would apply with your spouse's coverage.

This advance notice will allow your spouse the opportunity to enroll for coverage during the normal open enrollment period provided by most employers during the fourth quarter of each year. Enclosed is the Fund's form that will need to be completed by your spouse's employer and forwarded to the Fund office for review.

Should your spouse not follow the Fund rules and "opt out" of the employer's benefit plan, your spouse will not be covered as an eligible dependent under the Plan when this occurs, regardless of the reason.

If your husband or wife "opts out" of coverage as described above, and the standard Coordination of Benefits rules would cause your spouse's plan, if elected, to be the primary payer of benefits for your dependent children, such dependent children will not be covered as eligible dependents under this Plan. Refer to the Coordination of Benefits Rules in Section 5 for primary coverage information.

Enclosed is a summary sheet that will assist you in determining when your spouse will be primary (along with the covered dependents) and when you as the Teamster member will be primary.

The required Spouse Employer Form is also enclosed. This will need to be completed by your spouse's employer and forwarded to the Fund Office for processing during the fourth quarter of 2009. Please keep in mind, that this is for an effective date of January 1, 2010 and should reflect the health rates for this period.

All spouses will need to re-qualify for this provision annually beginning in 2010. Requalification will begin during the fourth quarter of each year.

If you have any questions or need assistance in clarifying this change, please contact the Health Fund at 315.455.9790 or 1.877.698.3863 and select Option 1.

Sincerely,

BOARD OF TRUSTEES
NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND

SPOUSE RESPONSIBILITY FOR ENROLLING IN HEALTH INSURANCE COVERAGE THROUGH THEIR EMPLOYER

Marital Status	Spouse Employer Plan	Teamster Coverage
Two Person	Determined 0% - 5% cost of health insurance. <ul style="list-style-type: none"> Spouse takes single, primary. 	<ul style="list-style-type: none"> Teamster Member Covered, primary Spouse has secondary
Two Person	Determined over 5% cost of health insurance. <ul style="list-style-type: none"> Spouse can waive coverage. 	<ul style="list-style-type: none"> Teamster Member Covered, primary Spouse covered, primary
Family	Determined 0% - 5% cost of health insurance on Individual and Family. According to Birthday Rule: Spouse DOB earlier ; <ul style="list-style-type: none"> Spouse takes family, primary. 	<ul style="list-style-type: none"> Teamster Member Covered, primary Spouse and dependents covered, secondary
Family	Determined 0% - 5% cost of health insurance on Individual and Family. According to Birthday Rule: Spouse DOB later ; <ul style="list-style-type: none"> Spouse takes single, primary. Dependents covered under Teamster. 	<ul style="list-style-type: none"> Teamster Member Covered, primary Dependents covered, primary Spouse covered, secondary
Family	Determined 0% - 5% cost of health insurance on Individual but over 5% on Family. According to Birthday Rule: Spouse DOB earlier ; <ul style="list-style-type: none"> Spouse takes single, primary. Dependents covered under Teamster. 	<ul style="list-style-type: none"> Teamster Member Covered, primary Dependents covered, primary Spouse covered, secondary
Family	Determined over 5% cost of health insurance in Individual and Family. <ul style="list-style-type: none"> Spouse can waive coverage. 	<ul style="list-style-type: none"> Teamster Member Covered, primary Spouse and dependents covered, primary

New Plan Provision:

For coverage beginning January 1, 2010 this percent is being increased to 5%. If the cost of a single or family coverage medical plan for your spouse is 5% or less of the spouse's wage, your spouse must enroll in their employer's health plan. The spouse's employer plan will provide primary coverage for the spouse and dependents claims (according to the Birthday Rule)* with the Fund's plan providing secondary coverage. The standard Coordination of Benefit rules would apply with your spouse's coverage.

The Birthday Rule is the parent whose birthday (month and day) is earlier in the year is primary.

New York State Teamsters Council Health and Hospital Fund

PO Box 4928
Syracuse, NY 13221-4928
Telephone: 315.455.9790
Fax: 315.234.1046
E-mail: benefits@nytfund.org

This form must be completed by Spouse's employer

Your Employee: _____

Our Insured: _____ ID# _____

Under the rules of The Fund, if a spouse of our member is eligible to be covered under their employer's benefit plan as an employee and is eligible for such group coverage, or receives a monetary payment, and declines to enroll for such coverage (opts out), the spouse and eligible dependents will not be covered as eligible dependents under this Plan, regardless of the reason.

Is employee eligible for health benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If no, please explain _____					
If yes, please indicate EMPLOYEE'S WEEKLY contribution for BOTH Single/Family:					
Single \$ _____		Family \$ _____			
Indicate gross average weekly earnings: \$ _____					
If employee is enrolled in health insurance complete the following:					
HOSPITAL	MEDICAL	MAJOR MEDICAL	DENTAL	RX PLAN	OPTICAL
<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family
_____	_____	_____	_____	_____	_____
Effective Date	Effective Date	Effective Date	Effective Date	Effective Date	Effective Date
Carrier Name					
Policy Number					

If employee is not currently enrolled, when is the next open enrollment? _____

Company Name _____

Address _____

Signature/Title _____

Date _____

Telephone Number _____

Fax Number _____

Thank you for

your cooperation.

NEW YORK STATE TEAMSTERS COUNCIL HEALTH & HOSPITAL FUND

SUPREME BENEFITS

SUPREME BENEFITS SUMMARY	In Network	Out of Network
Coinsurance	20%	20%
Copayment	\$10	\$10
Deductible	\$100 Individual / \$250 Family Combined In and Out of Network	
Out of Pocket Maximum (excludes deductible and copayment)	None	None
Lifetime Maximum Benefit:	\$1,000,000 Combined In and Out of Network	
HOSPITAL / FACILITY BENEFITS:		
Inpatient:		
unlimited days semi-private room and board	Covered in Full	Allowable Amount
other hospital-provided services, facilities, supplies, equipment	Covered in Full	Allowable Amount
maternity	Covered in Full	Allowable Amount
newborn nursery care	Covered in Full	Allowable Amount
skilled nursing facility (unlimited days)	Covered in Full	Allowable Amount
inpatient mental health care – 30 day benefit	Covered in Full	Allowable Amount
inpatient chemical dependency care – 42 days per calendar year	Covered in Full	Allowable Amount
Outpatient:		
surgery	Covered in Full	Allowable Amount
pre-surgical testing	Covered in Full	Allowable Amount
respiratory, cardiac therapies	\$10 Copayment	\$10 Copayment
chemo/radiation therapy	Covered in Full	Allowable Amount
physical, occupational therapies Limit: 24 visits each, per calendar year	\$10 Copayment	\$10 Copayment
speech therapy	\$10 Copayment	\$10 Copayment
diagnostic machine tests	Covered in Full	Allowable Amount
diagnostic x-ray examinations	Covered in Full	Allowable Amount
diagnostic laboratory	Covered in Full	Allowable Amount
kidney dialysis	Covered in Full	Allowable Amount
emergency care – waived if admitted	\$100 Copayment per visit	\$100 Copayment per visit
routine mammography screening – 35 and older – 1 per calendar year	Covered in Full	Allowable Amount
routine cervical cancer screening – 18 and older	Covered in Full	Allowable Amount

SUPREME BENEFITS SUMMARY	In Network	Out of Network
Other Institutional:		
home health care	Covered in Full	Allowable Amount
hospice	Covered in Full	Allowable Amount
birthing center	Covered in Full	Allowable Amount
ambulatory surgery center	Covered in Full	Allowable Amount
PROFESSIONAL (MEDICAL/SURGICAL):		
office visits	\$10 Copayment	\$10 Copayment
well child visits up to age 19	\$10 Copayment	Not Covered
inpatient visits	\$10 Copayment	\$10 Copayment
surgical procedures	Covered in Full - Inpatient	Allowable Amount
	Covered in Full – Outpatient	Allowable Amount
	\$10 Copayment – Physician Office	\$10 Copayment
surgical assistance	\$10 Copayment	\$10 Copayment
elective sterilization	Covered in Full	Allowable Amount
anesthesia	Covered in Full	Allowable Amount
maternity care & delivery	Covered in Full	Allowable Amount
emergency care	\$10 Copayment	\$10 Copayment
chiropractic services Limit: 16 visits per calendar year	\$10 Copayment	\$10 Copayment
diagnostic x-ray examinations	Covered in Full	Allowable Amount
diagnostic machine tests	Covered in Full	Allowable Amount
laboratory tests	Covered in Full	Allowable Amount
chemo/radiation therapy	Covered in Full	Allowable Amount
respiratory, cardiac therapies	\$10 Copayment	\$10 Copayment
physical, occupational therapies Limit: 24 visits each, per calendar year	\$10 Copayment	\$10 Copayment
speech therapy	\$10 Copayment	\$10 Copayment
allergy testing – office visits	\$10 Copayment	\$10 Copayment
allergy treatment – injection & serum	\$10 Copayment	\$10 Copayment
kidney dialysis	Covered in Full	Allowable Amount
routine mammography screening - 35 and older - 1 per calendar year	Covered in Full	Allowable Amount
routine GYN visit	\$10 Copayment	\$10 Copayment
prostate cancer screening	Covered in Full	Allowable Amount
bone density testing	Covered in Full	Allowable Amount

SUPREME BENEFITS SUMMARY	In Network	Out of Network
routine cervical cancer screening - 18 and older	Covered in Full	Allowable Amount
second surgical / medical opinion	\$10 Copayment	\$10 Copayment
annual routine physical	\$10 Copayment	\$10 Copayment
adult immunizations	\$10 Copayment	Not Covered
outpatient mental/nervous care: 30 visits per calendar year	\$10 Copayment	\$10 Copayment
outpatient chemical dependency: 60 visits, includes 20 family visits/calendar year	\$10 Copayment	\$10 Copayment
diabetes education equipment and supplies	\$10 Copayment	\$10 Copayment
ambulance	Covered in Full	Allowable Amount
consultation - office	\$10 Copayment	\$10 Copayment
consultation - hospital inpatient	\$10 Copayment	\$10 Copayment
DME/external prosthetic/medical supplies	Deductible/Coinsurance	Deductible/Coinsurance
Hearing examinations: diagnostic and for the purpose of prescribing, fitting, or servicing hearing aids	\$250 allowance every 3 calendar years. Children under 13, are allowed up to \$250 every calendar year under certain medical conditions.	Deductible/Coinsurance -up to \$250 allowance every 3 calendar years. Children under 13, are allowed up to \$250 every calendar year under certain medical conditions.
Hearing Aids prescribed by a physician. Over the counter hearing aids are excluded.	\$1,000 allowance every 3 calendar years. Children under 13, are allowed up to \$1,000 every calendar year, per ear under certain medical conditions.	Deductible/Coinsurance -up to \$1,000 allowance every 3 calendar years. Children under 13, are allowed up to \$1,000 every calendar year, per ear under certain medical conditions.

PRE-APPROVAL is required for **ALL** inpatient admissions and home health care. For Elective admissions call at least 7 days prior. Emergency admissions call within 2 business days. **A penalty of \$500 or 50% of the benefits payable whichever is less, will be imposed if you do not comply with the pre-approval requirements.** Call your Dedicated Service Unit at 1-877-650-5840 for assistance.

******* ALL BENEFITS ARE SUBJECT TO MEDICAL NECESSITY GUIDELINES. *******

Allowable Amount – Plan payment at procedure code up to Allowable Amount.

In Network Provider – will accept payment up to Allowable Amount as paid in full.

Out of Network Provider – will balance bill up to charges.

SUPREME PRESCRIPTION DRUG BENEFITS

Retail Pharmacy – Acute 30 day supply

Generic	\$5.00 copay
Brand – Preferred	\$10.00 copay
Brand – Non Preferred	\$25.00 copay

Retail Pharmacy – Maintenance 90 day supply

Generic	\$15.00 copay
Brand – Preferred	\$30.00 copay
Brand – Non Preferred	\$75.00 copay

Mail Order – Maintenance 90 day supply

Generic	\$10.00 copay
Brand – Preferred	\$20.00 copay
Brand – Non Preferred	\$50.00 copay

Please Note: If a Brand name medication is received and a generic equivalent is available, the participant must pay the Brand name copay **PLUS** the difference in the cost between the generic equivalent and the Brand name medication.

New York State Teamsters Council Health and Hospital Fund

PO Box 4928
Syracuse, NY 13221-4928
Telephone: 315.455.9790
Fax: 315.234.1046
E-mail: benefits@nytfund.org

July 30, 2009

Dear Participant:

Enclosed are important Summary Material Modification notices and information regarding your coverage under The New York State Teamsters Council Health & Hospital Fund. Please read this information carefully.

This mailing includes the:

- Summary Material Modification notice dated July 30, 2009.
 - Identifying what is the Michelle Law requirements.
 - Identifying the State Children's Health Insurance Program (CHIP).
- Summary Material Modification notice dated July 30, 2009.
 - Identifying Plan design changes with the effective dates of October 1, 2009 and January 1, 2010.
- **Coordination of Benefit "Opt Out" packet.** If you are married and your spouse works for an employer that provides health insurance, he or she will be required to re-qualify under the revised "Opt Out" percentage of 5% (previously 2%). This form must be completed and returned to the Fund Office during the fourth quarter of 2009.
- A new Summary Sheet for your Medical Plan effective October 1, 2009.

If you have any questions, please contact the Health Fund Office at 315.455.9790 or 1.877.698.3863 and select Option 1.

The Board of Trustees

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**SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO PARTICIPANTS**

**NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND**

(Plan No.: 501; I.D. No.: 15-0551885)

July 30, 2009

Dear Participant:

This letter contains important information regarding changes adopted by the Board of Trustees of the New York State Teamsters Council Health and Hospital Fund (the "Fund"), as well as certain additional notices required under federal law. You should keep this letter with your copy of the Summary Plan Description for the Fund.

The Fund changes are summarized as follows:

1. Section 3, **Eligibility for Fund Benefits**, Subsection J, **Dependent Eligibility**, is amended effective January 1, 2010 to include the following language relating to coverage for unmarried eligible children who are full time students. The following paragraph is inserted at the end of the section titled Full Time Student in No. 2:

If a full-time student is required to take a medically necessary leave of absence from school, the Fund's coverage will continue upon receipt of a written certification of medical necessity by a treating physician. Coverage will continue until the earlier of either one year after the first day of the medically necessary leave of absence or the date when the coverage would otherwise terminate under the Fund. The physician's written certification must state that the student is suffering from a serious illness or injury and that the leave of absence or other change in student enrollment is medically necessary. A "medically necessary leave of absence" means a leave of absence from an institution, or any other change in the student's enrollment, that commences while the student is suffering from a serious illness or injury, is medically necessary and would otherwise cause the student to lose full time student status for purposes of Fund coverage.

2. Section 3, **Eligibility for Fund Benefits**, Subsection L, **Special Enrollment Rights**, has been amended to read as follows, effective April 1, 2009:

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to

enroll yourself or your dependents in the Fund under the following circumstances: (1) your spouse loses coverage as a result of a job loss; or (2) your spouse's employer no longer offers health benefits to any employees. In either case, you must request enrollment within thirty (30) days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption.

You and your dependents may also enroll in the Fund if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in the Fund if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

It is important to promptly notify the Fund Office of any change in your family status due to marriage, birth of a child, death, divorce or judicial order of legal separation or any change of address.

If you have any questions, please contact the Fund Office at 315.455.9790 or 1.877.698.3863 and select Option 1.

Sincerely,

BOARD OF TRUSTEES
NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND